LOS ANGELES COUNTY COMMISSION ON HIV

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COMMISSION ON HIV
MEETING MINUTES
May 8, 2014

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT *(cont.)*	COMMISSION MEMBERS ABSENT	DHSP STAFF
Michael Johnson, Esq., *Co-Chair*	Brad Land	Raquel Cataldo	Kyle Baker
Ricky Rosales, *Co-Chair*	Ted Liso/Douglas Lantis, MBA	Suzette Flynn	Wendy Garland, MPH
Alvaro Ballesteros, MBA	Patsy Lawson	David Giugni, LCSW	Melissa Roldan
Joseph Cadden, MD	Rob Lester, MPP	AJ King, MPH	Juhua Wu, MA
Kevin Donnelly	Abad Lopez	Victoria Ortega	Carlos Vega-Matos, MPA
Michelle Enfield	Miguel Martinez, MSW, MPH	Terrell Winder	Dave Young
Lilia Espinoza, PhD	Marc McMillin	Fariba Younai, DDS	
Dahlia Ferlito, MPH *(pending)*	José Munoz		
Aaron Fox, MPM	Angélica Palmeros, MSW		**COMMISSION STAFF/CONSULTANTS**
Lynnea Garbutt	Mario Pérez, MPH		
Terry Goddard, MA	Gregory Rios		Dawn McClendon
Grissel Granados, MSW	Juan Rivera/Rev. Alejandro Escoto, MA		Jane Nachazel
Joseph Green/Erik Sanjurjo, MA	Jill Rotenberg		James Stewart
Kimler Gutierrez *(pending)*	Sabel Samone-Loreca/Susan Forrest		Craig Vincent-Jones, MHA
Sharon Holloway	Shoshanna Scholar		
David Kelly, MBA, JD	Terry Smith, MPA		
Ayanna Kiburi, MPH	LaShonda Spencer, MD		
Lee Kochems, MA/James Chud, MS	Monique Tula		
Mitchell Kushner, MPH, MD	Richard Zaldivar		
PUBLIC			
Robert Aguayo	Darren Aiken	Stacy Alford	Herman Avilez
William Bowman	Kurt Cabrera-Miller	Virginia Cabria	Ad Cervantes
Efren Chaca	Geneviéve Clavreul	Edd Cockrell	I. Jean Davis, PA
Mark Davis, DDS	Erika Davies	Shae Flanigan	Donnie Frazier
Eileen Garcia	Thelma Garcia	Jerry Gates	Bridget Gordon
Gabriel Green	Faith Idemundia	Miki Jackson	Mike Jones
Uyen Kao	Joseph Leahy	Tom Levy, DDS	Eric Paul Leue
Aldo Macias	Andres Magana	Steve Mercieca	Arty Milborn

PUBLIC *(cont.)*			
Anthony Mills, MD	Kieta Mutepfa, MSW	Sasha Navarro	Ernesto Provencio
Laura Ramos	Darwin Rodriguez	Martha Ron	Natalie Sanchez
Walt Senterfitt	Piedad Suarez, DDS	Emmanuel Tapia	Joey Terrill
Brigitte Tweddell	Jason Wise	Will Watts	

1. **CALL TO ORDER**: Mr. Johnson opened the meeting at 9:05 am. Mr. Rosales welcomed new Commissioner Miguel Martinez and congratulated former Alternate Kevin Donnelly on his appointment to a full Commission seat.
   A. Roll Call (**Present)**: Caddan, Donnelly, Enfield, Espinoza, Ferlito, Fox, Garbutt, Goddard, Granados, Green, Gutierrez, Johnson, Kelly, Kiburi, Kushner, Land, Lawson, Lester, Liso/Lantis, Lopez, Martinez, McMillin, Munoz, Pérez, Rios, Rivera, Rosales, Rotenberg, Samon-Loreca/Forrest, Smith, Spencer, Tula, Zaldivar

2. **APPROVAL OF AGENDA**:
   MOTION 1: Adjust, as necessary, and approve the Agenda Order ***(Passed by Consensus)***.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION 2: Approve minutes from the February 13, 2014, March 13, 2014 and April 10, 2014 Commission on HIV meetings, revised as appropriate, as presented ***(Postponed)***.

4. **PUBLIC COMMENT *(Non-Agendized or Follow-Up)*:**
   - Dr. Cabrera-Miller, Northeast Valley Health Corporation, announced the PLAG Santa Clarita Chapter is hosting its First Annual Community Barbeque on 5/24/2014, 2:00 to 6:00 pm, to bring the community together. He urged providers to reach out to clients. Scholarships are available for the $5 cost. Flyers were on the resource table.
   - Mr. Johnson read comments provided by Dr. Younai who was unable to attend. Dr. Younai said providers and consumers understand there is a proven bidirectional relationship between oral and systemic health in HIV disease. Like other chronic diseases, oral disease compounds over time leading to poor oral and systemic health outcomes.
   - Financially, deferred oral health care results in costs doubling or tripling over a relatively short period of time.
   - The Denti-Cal formulary implemented 5/1/2014 is far below the County's standards. It does not appropriately preserve natural teeth by endodontic and quality prosthodontic treatments. There are no provisions for complex surgical procedures or those with chronic orofacial pain/neuropathies, temporomandibular joint disorders or oral soft tissue lesions that require ongoing diagnosis and treatment. She urged DHSP to address issues and find solutions for the immanent funding shortfalls.
   - Dr. Davis is Dental Director, AIDS Healthcare Foundation, and has provided dental care for PLWH since 1997. Adult Denti-Cal has very limited services. He thanked DHSP for meeting with providers, but there are major issues with maintaining oral health services, e.g., it only covers root canals on the front six teeth which is disrupting the system that refers patients with specialty needs to USC. Denti-Cal eligible patients are not receiving planned posterior root canals since Ryan White cannot fund services covered by another funder. Services are already disrupted due to the lack of a Ryan White wrap-around.
   - Dr. Levy, Clinical Director, Endodontics, USC, said 352 patients were seen in 2013. Most had multiple endodontic problems, e.g., infections and related problems with other teeth. Since 5/1/2014, 18 to 20 previously referred patients were declined since they also had Denti-Cal. Three scheduled patients were cancelled in one day. Fifteen were declined in four days.
   - Dr. Suarez, Co-Director, Special Patients Clinic, USC, added some Denti-Cal patients are covered by the Denti-Cal HMO. USC is not a Denti-Cal HMO provider so cannot see them at all. Other Denti-Cal patients may have a share-of-cost, but many cannot pay. Yesterday, services for a patient with notable infection had to be delayed in hopes of negotiating a way to pay.
   - The list of covered Denti-Cal treatments, included in the packet, is minimal. It does not even cover scaling and root planing which is a major need. Yesterday, a patient declined that service because it would cost $66 per quadrant.
   - Mr. Pérez said DHSP has become aware in the last few days of changing healthcare financing issues pertaining to oral health. The Commission made PLWH oral health access a priority. The County arguably has the best system in the country.
   - He urged oral health providers, especially USC, not to turn patients away. DHSP understands Ryan White is an important resource and that the re-introduction of Denti-Cal has created some important policy issues that need to be addressed. DHSP committed at the prior week's Oral Health Advisory Committee (OHAC) meeting to work through key issues.
   - First, based on experience with Medi-Cal and Denti-Cal, DHSP knows there are coverage and payment issues to address. DHSP has a long-standing commitment to ensure Ryan White funds services not otherwise covered, e.g., Ryan White can

cover a posterior crown since Denti-Cal does not. DHSP is operationalizing that support, but patients should be seen in the meantime. It is hard to get patients to schedule an appointment so it is important to keep those appointments.

- There is a new rule for Federally Qualified Health Centers (FQHCs) based on a legal ruling that will cover more services. That will help those providers that are part of an FQHC network. Not all providers are.
- Standards of care is another key concern and one that will require considerable work. DHSP has contacted HRSA concerning guidance to ensure providers bill procedures to the appropriate funder, i.e., Ryan White or the state. Standards issues such as the quality of a crown impact those deliberations and, while deliberations will be expedited as much as possible, information continues to change with new information received just the day before. There are 14 Ryan White oral health partners in the County. DHSP will work with them to address payment concerns. Patients should be seen meanwhile.
- Mr. Land felt Fee-For-Service (FFS) was essential to enable DHSP to coordinate with other payer systems for oral health, mental health and other categories in which other funders do not fund some of the services. Providers do not want to turn away patients, but need assurance they will be paid. He felt FFS will help communicate on service codes.
- Mr. Pérez stated DHSP has never said FFS is the only way to address provider payment issues. This issue is solely due to complications consequent to re-introduction of Denti-Cal. Overall, re-introduction of Denti-Cal is good, but it has complicated some matters for PLWH who have historically relied on Ryan White and whose eligibility is now more complex. He felt discussing other service categories in this context was inappropriate.
- Ms. Palmeros said she had understood there was no transition period and patients did need to be turned away. Dr. Davis said he as well as Drs. Levy, Martinez, Suarez, Washington and Younai all perceived OHAC meeting information that way.
- Mr. Vega-Matos attended the OHAC meeting. DHSP did not say to refuse patients, but that it currently lacked a mechanism to bill Ryan White. Further, two providers are not Denti-Cal providers. Ryan White cannot cover services Denti-Cal covers.
- Dr. Suarez said providers do not want to refuse patients, but most patients turned away require fees to be prepared and sent to the laboratory. Providers need a process for those patients who are both Ryan White and Denti-Cal eligible. There was no transition process in place and the number of these dual eligible patients was higher than expected.
- Dr. Levy said USC, as a healthcare university, provides specialty services. He understood treatment could only be provided on teeth covered by Denti-Cal if the patient was eligible, but most patients need work on uncovered posterior teeth.
- Mr. Fox confirmed the situation changes daily. The Department of Health Care Services (DHCS) just completely changed FQHC and Rural Health Center Denti-Cal policies after they were supposedly done. DHCS is causing most of the problems.
- The Center does not provide oral health care but, had he attended the OHAC meeting and perceived DHSP to say patients should be turned away, he would have ignored them. Providers also have a role in ensuring they can serve clients. Denti-Cal has been in the budget since July 2013 and was expected to start 5/1/2014. Providers not set up to bill Denti-Cal should have corrected that prior to implementation and explored other means to ensure continuity of care for their clients.
- Mr. Zaldivar added there was no major funding when the AIDS epidemic began. People came together to help each other. That spirit should be re-invigorated today, raising funds as nonprofits do, to ensure patient needs are met.
- He asked about the scope of patients declined. Dr. Levy said approximately 40% of the week's endodontic referrals was declined. There are 50 to 60 referrals weekly. Patients with Denti-Cal who required work on posterior teeth, the majority of patients, were declined either in person or by phone. Denti-Cal only covers anterior teeth.
- Mr. Kelly has been Medi-Medi for years and has had access to oral health services, but it has historically been a hodge-podge with some oral health services one place and others another. He suggested consumer education on service access.
- Mr. Vincent-Jones appreciated Mr. Pérez's passionate support for the oral health system developed over time. He also appreciated, however, providers' concerns about being paid for appointments especially when payment for some 40% of patients is at risk. He felt providers sought a commitment that they will eventually receive retroactive payment.
- He noted a motion on the agenda would shift $1 million in Net County Cost (NCC) to Part B. NCC could be used to fund a bridge program. Issues are solvable, but it will take time to review Denti-Cal services, identify which are separate or can be supplemented by Ryan White and identify justifications for Ryan White funding. The work could extend to several months with patients losing access meanwhile. While not an FFS issue per se, he felt FFS questions would also need to be reviewed.
- He asked if a Treatment Access Request (TAR) could be an access option. Dr. Davis spoke to a Denti-Cal provider relations specialist on 5/7/2014. A service not on the list, e.g., posterior root canals, will not be approved barring a "dire medical emergency." It may be considered if the patient "needs a liver or kidney transplant." FQHCs may have different criteria.
- Mr. Vincent-Jones asked if OA was aware of the situation and, if so, what action it was taking. Ms. Kiburi said OA was aware. A DHCS representative is on the OA Stakeholder Advisory Committee. OA continues to talk with DHCS to understand how to better support the process. She stressed Ryan White can be used to fund a service not funded by another payer source.

- Mr. Vincent-Jones added standards of care were not written based on what Ryan White could fund, but on what was the best minimum standards of care possible. The limited Denti-Cal services contradict the Oral Health Standards of Care. If Ryan White cannot fund services in a quality manner then it is up to the Commission to identify other resources.
- Ms. Palmeros reported the City of Pasadena has not refused patients, but many now have a co-payment of $20 or $50. She hoped Ryan White could offer supplemental assistance based on income. Some patients are cancelling appointments.
- Mr. Pérez replied that added a new issue emerging as part of the Denti-Cal restoration. The Commission has discussed share-of-cost and co-payments previously, but DHSP has no efficient mechanism to address them anywhere in the system.
- It was important to recognize this is a transition period with rules changing. The state, Department of Public Health, DHSP and its 14 partners must work jointly to ensure the network is as tight as possible to preserve continuity of care.
- Two of three key issues pertain to funding. Regarding payment shortfalls, HRSA rules prohibit use of Ryan White funds to supplement Denti-Cal payment for covered service, e.g., cleaning. Regarding coverage shortfalls, Ryan White can fund services Denti-Cal does not, e.g., posterior crowns, just as it can cover needed mental health visits beyond other coverage.
- Dr. Davis said the issue was posterior root canals. Mr. Pérez said he used the example Craig Thompson provided. Mr. Vega-Matos is comparing Denti-Cal services versus the standard to identify what services Ryan White can be expected to cover.
- Mr. Pérez added the issue with standards does not only apply to oral health. Ryan White will continue to face the issue of how to supplement services as ACA roles out if health plans continue to provide a menu of services that is not as robust as Ryan White. DHSP will continue to push for health plans to do the right thing and provide appropriate coverage.
- DHSP has contacted Dr. Timothy Martinez and will try to develop a standard review timeline more aggressive than four to six weeks. He cautioned, however, HRSA rulings apply nationwide so they are likely to engage in considered deliberations.
- DHSP appreciates the Commission's Oral Health Care Standards of Care for the Ryan White system, but they do not always influence Denti-Cal or health plan standards. HRSA appreciates the PLWH differential, but may not support, e.g., porcelain crowns versus the stainless steel covered by Denti-Cal. Those are the kinds of answers DHSP will seek from HRSA.
- Oral health contracts, like others that share the Ryan White grant cycle, restarted 3/1/2014. DHSP has delegated authority to adjust the contracts by 10% with DPH endorsement and notice to the Chief Executive Office and the Board. Approval to use the delegated authority should not be a problem and resources are available to increase funding.
- USC is the County's trusted endodontic provider. All providers funnel those cases to USC for the complex, invasive and expensive services. A 10% increase may be insufficient. Further increases would need to be approved by the Board.

➲ Ms. Kiburi will continue to update the Commission on issues pertinent to implementation of Denti-Cal.

➲ Mr. Pérez will distribute a policy statement by noon 5/9/2014 to the 14 oral health providers clarifying use of Ryan White funds for services not covered by Denti-Cal and its inability to supplement Denti-Cal payment for covered services.

➲ DHSP will work to clarify standards with HRSA as expeditiously as possible. DHSP hopes to meet with the 14 oral health providers in 10 to 14 days to present resolution on the standards of care issue and to ensure consistent procedures.

5. COMMISSION COMMENT *(Non-Agendized or Follow-Up)*:

- Ms. Forrest announced that the HIV Drug and Alcohol Task Force with the UCLA Integrated Substance Abuse Program is presenting a three-hour synthetic drugs training on 6/20/2014. Registration is $7. Forms were on the resource table
- Mr. Kelly suggested adding an email contact to the address information on the agenda to encourage community feedback. He also suggested including Commission staff openings in the packet and publicly posting them.
- Mr. Vincent-Jones agreed to add the email. Positions cannot always be opened to the public in the County's hiring process.
- Dr. Kushner wanted the record to reflect that the City of Long Beach, Department of Health, HIV Clinic remained unable to secure a Medi-Cal contract. It is a major challenge. The City had, with effort, secured a Healthy Way LA (HWLA) contract and has worked since October 2013 to secure one with LA Care and Health Net, but they cannot contract directly with the City.
- An Independent Physician Association (IPA) has to first accept the City as a specialty or primary care provider, but the main IPA covering PLWH in Long Beach will not accept City clients. The IPA did not respond to him for months. When it did, the IPA said Long Beach already had sufficient HIV providers and the IPA did not want to accept any more risk with PLWH. Dr. Kushner reported Long Beach has over 4,500 PLWH clients. He is seeking another IPA, but they are leery of accepting PLWH.
- The City's 90 to 100 clients have been transitioned to other providers contracted with LA Care or Health Net. Continuity of care is not being respected. Community providers say it does not apply since the City is not a contracted provider.
- Some clients are refusing to leave their current care to go to another provider. The City has not turned anyone away, but has provided service without reimbursement since 1/1/2014. That will affect other services beyond those for PLWH.
- Dr. Kushner added the City is also being blocked from contracting for the just released HWLA Unmatched Request for Statement of Qualifications (RSQ). The City is challenging that because it represents a large proportion of its patients. The

City was told verbally when it had a HWLA contract that it would be part of this process, but is now being told it does not qualify because it is not an FQHC. The City is collaborating with other Long Beach providers for the RSQ challenge.

- ➲ A Commission email contact will be added to the Commission agenda's address information.
- ➲ Dr. Kushner will provide a follow-up report on the City's efforts to contract with IPAs at the June meeting. The report will include identifying those IPAs which are refusing to accept additional PLWH clients.
- ➲ Refer the marketplace and County policy issues pertinent to the City of Long Beach situation to Public Policy.

6. **CONSENT CALENDER**:
   - **A. Policy/Procedure #08.2107: Consent Calendar**:
     MOTION 3: Approve the Consent Calendar with agenda motions 4, 9, 10, 11 and 12 removed ***(Passed by Consensus)***.

7. **CO-CHAIRS' REPORT**:
   - Mr. Rosales attended the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) meeting over the last four days. A key topic was review of UCHAPS as an organization especially how it could improve its efficiency in providing Technical Assistance (TA) to directly funded jurisdictions and partners. UCHAPS will offer TA for the current FOA as it has in the past.
   - UCHAPS met with Dr. Merman, CDC, primarily on how to move forward on PrEP, how PrEP works in different jurisdictions and the response to hepatitis. The national hepatitis response is poor and the CDC wants a focus on it along with STDs.
   - UCHAPS also heard a presentation from Mr. Young, HRSA, which included HRSA moving forward with a public health approach to Ryan White. Discussion was minimal, but it is new phraseology so HRSA's interpretation should be watched.
   - ➲ Mr. Rosales will provide a more complete report on the UCHAPS meeting at a later date.

8. **EXECUTIVE DIRECTOR'S REPORT**:
   - Mr. Vincent-Jones noted the National Quality Center Training of Consumers in Quality scholarship application in the packet. The deadline was 5/9/2014, but it was just received so the National Quality Center has extended the deadline to 5/12/2014.
   - The Commission will help facilitate applications for the 5/20-21/2014 Oakland event and supplement uncovered expenses. Interested Commission members should contact him or Dawn McClendon after the meeting to coordinate paperwork.
   - Ms. Lawson, Mr. Liso and Ms. Garbutt have attended before and can offer their experiences. Ms. Garbutt noted training is intense and includes a large amount of material. She offered to share her materials with interested Commission members.
   - Mr. Liso said the training prepares consumers to raise quality assurance in discussions about services and standards. Information will also be helpful in planned OA quality management meetings.

   A. Commission Meeting Business:
   - Mr. Vincent-Jones reported the Commission continues to experiment with ways to improve the meeting.
   - Committee Co-Chairs will sit together, but need not sit the head table. That happened accidently last month and facilitated engagement. Presenters, including Committee Co-Chairs, will report from the podium for better visibility.
   - Meeting energy seems to fade around noon so lunch will be added in an effort to counter fatigue. Provision of lunch will likely start in June. That would coincide with a meeting which is also being planned for the full day.
   - Several Commission members have asked when their terms expire. The monthly roster now shows expiring terms reversed out. The Ordinance specifies scattered terms so no more than half of the body is replaced each year. To initiate that process, the roster of seats was assigned alternating terms ending in 2014 or 2015 before people applied.
   - ➲ Dr. Espinoza and Mr. Green will assist Messrs. Liso, Lantis and Vincent-Jones in developing meeting evaluations.

9. **PARLIAMENTARY TRAINING**:
   - **A. "Divide the Question"/Seriatim**:
   - Mr. Stewart reviewed the two parliamentary processes for addressing long, involved documents.
   - "Divide the question" divides a document into two or more motions rather than one. Each new motion is debated and voted separately. For example, Motion 13, the 2104 Legislative Docket can be divided since each part is independent.
   - The "seriatum" process addresses a long document by going through it one part at a time and then voting once on the entire document. Motion 11 on PrEP cannot be divided because it is all interrelated so would require "seriatim."
   - "Divide the question" is used whenever a document can be divided. "Seriatim" is used if it cannot.

10. **CALIFORNIA OFFICE OF AIDS (OA) REPORT**:
    - **A. OA Work/Information**:

- Ms. Kiburi, Chief, HIV Care Branch reported OA participated in the California STD Controllers Association and California Conference of Local AIDS Directors meeting on 4/8-10/2014 in Oakland. OA staff presented on OA updates, priorities. HIV/STD collaboration activities and efforts to expand use of surveillance data for partner services. OA staff also served on a panel that discussed the HIV continuum of care from both the prevention and care viewpoints.
- Regarding the Part B HIV Care Program, OA released a Health Care Reform (HCR) Communications Plan in partnership with DHCS and HIV stakeholders on 4/4/2014. The Plan was requested by the Stakeholder Advisory Committee and other advocates. It outlines OA strategies and objectives in communicating to stakeholders about changes to health care coverage and services for Ryan White clients and PLWH related to the ACA. It will be updated as needed to ensure HCR communications help inform PLWH and providers about changes and impacts to the Ryan White system of care. It is available on the OA website at www.cdph.ca.gov/programs/aids/Documents/OADHCSHCRCommunicationPlan.pdf.
- Amy Kite-Puente was named Chief, HIV Prevention Branch on 4/10/2014. She joined OA in 2005 and has held a leadership role in statewide and local public health HIV prevention initiatives from inception through implementation and evaluation. She previously was HIV Prevention Programs Section Chief and worked with the CPG. In those roles she built collaborative relationships with the CDC, STD Control Branch, health department program staff and stakeholders.

B. California Planning Group (CPG):

- OA conducted a new CPG member orientation webinar on 4/11/2014. It was recorded and will be available shortly on the CPG webpage of the OA website at www.cdph.ca.gov/programs/aids/Pages/OACPG.aspx.
- The first in-person CPG meeting will be 6/25-26/2014 in Sacramento. Public comment will be accepted. The agenda will be on the CPG webpage at least 30 days prior to the meeting. Contact Liz Hall for questions at liz.hall@cdph.ca.gov.
- Mr. Vincent-Jones noted discussions two or three months ago regarding Anthem Blue Cross not accepting OA-HIPP co-payments from OA. He spoke with Dr. Karen Mark, Chief, about the issue. OA was aware of the problem, but not its cause despite being a serious contractual nonobligence matter. He had heard people were still experiencing problems.
- Mr. Rivera reported many consumers are having difficulty communicating with OA. Responses from their OA-HIPP enrollment workers about payments are not timely. Ms. Kiburi acknowledged a backlog. She will review OA response.

➲ Ms. Kiburi will forward a roster of CPG members including the areas they represent.
➲ Ms. Kiburi will report on the response to the issue of Anthem Blue Cross not accepting OA-HIPP co-payments.
➲ Ms. Kiburi will log the complaint about slow OA-HIPP responses, review OA corrective action and will report back.

11. **DIVISION OF HIV/STD PROGRAMS (DHSP) REPORT**:

A. Administrative Agency:

1) Maximizing State OA Part B Funds: Attendees stated their conflicts of interest.

- Mr. Pérez called attention to his letter to the Co-Chairs regarding redirection of Residential Care expenditures to the Ryan White Part B award. Terms are usually 12 months. Historically, though Ryan White Part B is on an April through March cycle, the state shifted its county awards to be consistent with the state's July through June cycle.
- They recently returned to the Ryan White Part B cycle so the term in question is nine months, July 2013 through March 2014. DHSP had approximately $6.3 million to invest in eligible Ryan White Part A or B categories including Oral Health, Substance Abuse Residential, Case Management Home-Based and Case Management Transitional.
- There was approximately $1 million in under-spending for the term in the noted categories especially Oral Health.
- DHSP is committed to not sending one state or federal dollar back. It had planned to bill various costs to other revenue streams including NCC, the County's general fund contribution to HIV. DHSP proposes moving $1 million in Residential Services costs from NCC to Part B to maximize the Part B grant. The action would not impact services.
- Mr. Goddard noted a previous adjustment prompted an extra state audit. Mr. Pérez commented the state reserves the right to confirm funds were spent per their rules. Mr. Young added DHSP will identify one provider with the highest NCC funding so only one new budget will be submitted to the state. That provider will be subject to audit.
- Mr. Vega-Matos stressed these are Ryan White dollars so all Ryan White requirements and state interpretation of how a funder may monitor providers are included in contracts. The state will review annual and six-month certifications and a cost allocation plan to which the provider adheres. Ryan White providers that adhere to the Ryan White requirements as translated in their contracts should meet all audit requirements.
- Mr. Vincent-Jones noted this action unencumbers approximately $1 million in NCC and asked how DHSP planned to use those funds. Mr. Pérez responded the NCC term does not end until 6/30/2014 so there is time for review.

➲ DHSP will offer a proposal to use the unencumbered $1 million in NCC funds at the next PP&A meeting.

MOTION 4: Modify FY 2013-2014 Ryan White Part B [State Office of AIDS (OA) Single Allocation Model (SAM)] allocations to include approximately $1,000,000 for residential care, in order to fully maximize Part B funding by the end of the State OA funding term ***(Passed: 34 Ayes; 0 Opposed; 2 Abstentions)***.

2) FY 2014 Ryan White Award:

- Mr. Pérez announced receipt of the Notice of Grant Award with an increase of $1.7 million for a total just under $40 million. It is the first time in years that the County received increases to the Minority AIDS Initiative (MAI), supplemental and formula portions. The award reflects a cogent MAI plan, acknowledgement of the County's proportion of the national epidemic in the formula and the quality of the application in the supplemental.
- DHSP will work with PP&A on recommendations for the additional funds. The contingency plan will not be needed.
- He thanked Dr. Michael Green, Ms. Wu and the rest of the DHSP staff who contributed to the application; the Commission members who provided feedback; and Mr. Vincent-Jones. The award is a significant achievement.

3) Invasive Meningococcal Disease (Meningitis) Update:

- Mr. Pérez reported there have been nine total cases to date with no new cases reported since 4/25/2014. There is a meningitis button on the DPH website, www.publichealth.lacounty.gov, for recent information on cases, a Frequently Asked Questions document, some presentations and one-page fact sheets.
- He thanked Commission members who helped develop materials targeted to MSM. Education efforts continue.
- Mr. Vincent-Jones expressed concern that the County and Long Beach cannot agree on recommendations. Once this situation resolves, there will be an opportunity to explore why the difference occurred and what protocols could mitigate differences in future. Divergent recommendations, at best, send mixed messages to the community.
- Dr. Kushner, Health Officer, City of Long Beach felt the difference is mainly semantic. The City is offering vaccine and has not refused anyone, but there have been few requests. The City seeks more data on uptake of the two doses for HIV+ men especially for those without a risk profile. There have been no cases among HIV+ men or MSM.
- Ms. Jackson, AIDS Healthcare Foundation (AHF), noted inaccurate press and internet information from the start. The County provided vaccine to partner clinics, but that is CDC-funded so distribution is limited to clients without insurance while County public health clinics accept all clients. That confused people. She felt the County should independently fund vaccine to ensure no restrictions. AHF was able to fund vaccine, but smaller clinics cannot.
- Mr. Pérez recognized differences between County and Long Beach jurisdictions. County recommendations were based on consultation with state public health leaders and the CDC. Of nine cases to date, six were men and three were women. Five of the men were MSM, four of those were HIV+ and three of the HIV+ MSM died. That data helped inform County vaccination recommendations. For PLWH, that is two doses over eight to twelve weeks.
- DPH learned not all clinics had vaccine on hand so there was a strong deployment to partners who requested it including AHF. The deployment expectation, repeated in calls with partners, was that this should be considered a down payment on the normal part of care for MSM who fit the risk profile or HIV+ MSM over the next month. Vaccine was pushed out in particular to Ryan White partners and will be billed to Ryan White as appropriate.
- Dr. Jonathan Fielding, Director, DPH sent a letter to health plans in the County urging they cover vaccine for all residents especially MSM and PLWH. DPH hopes private practitioners will also advocate for health plan coverage.
- Mr. Kochems, an HIV+ MSM living in Long Beach, became aware of varying County and Long Beach approaches at the April Public Policy meeting. By that evening, he had attended two other meetings and talked to 10 people who were unaware where vaccine was available in Long Beach. Others have since come to him with questions. He was distressed a scheduled Long Beach HIV Planning Group meeting was cancelled and the LGBT community did not appear to have been consulted. The core issue for him is poor community public health education.
- Dr. Kushner was disheartened Long Beach residents lacked information. The evening the news story broke, the website announced acquisition of over 200 doses of free vaccine regardless of insurance. The City also contacted all City medical providers and distributed a medical press alert. Mr. Kochems did not dispute that vaccine or information was available, but better outreach to the community at large was needed. Not all know where to go.
- Mr. Rivera shared his experience on the pharmacy level. Physicians requesting vaccine for patients with private insurance or Medicare had no difficulty obtaining it. Vaccine could not be dispensed for physicians requesting it for patients on the Health Net or LA Care Medi-Cal managed care plans because it is not on the formulary.
- Mr. Fox felt this related to discussions on oral health and PrEP. Funding for public health and the private sector, specifically health insurance, has changed dramatically. It is unfair to the County and consumers for private and Medi-Cal managed care plans to deny coverage as had happened to several people he has spoken with.

- He urged consumers to advocate with their physicians for vaccination and file a grievance or change physicians if refused. Meningitis vaccination is covered under the ACA without co-payment or co-insurance. Mr. Pérez added DHSP should be informed for follow-up. Other options include DHS, public health, FQHC and Ryan White clinics.
- ➲ Mr. Kochems asked Consumer Caucus members to discuss routine PLWH vaccination standards in committees.
- ➲ Messrs. Fox and Zaldivar, Public Policy Co-Chairs, and Messrs. Land and Liso, Consumer Caucus Co-Chairs, will develop patient advocacy grievance training.

B. HIV/STD Services: Mr. Pérez noted the new Morbidity Mortality Weekly Report. It highlights increased syphilis incidence nationwide. He suggested exploring that further at the next meeting as the County is also seeing a rise in infection.

1) Medical Care Coordination (MCC) Progress Update:

- Mr. Vega-Matos acknowledged the major undertaking required to ramp up this new, complex, countywide service, a Commission priority since 2007. DHSP continues to work with providers and offer technical assistance (TA).
- Primary MCC goals are: increase access to care with an increased proportion of PLWH engaged in care and improved access to prevention and care services; reduce HIV-related Health disparities with improved outcomes for PLWH and ultimately reduce new HIV infections; and promote retention in care for PLWH.
- Everyone receiving care in a medical home is eligible for MCC, but patients have varying acuity. Implementation focuses on those newly diagnosed in the last six months or who have been out of care for more than six months; are currently in care, but failing to adhere to the treatment plan; are adherent to the treatment plan, but failing to thrive; or are adherent, but exhibit high risk behavior for re-infection or transmission of HIV.
- DHSP contracts with 19 community-based providers and DHS for HIV Ambulatory Outpatient Medical (AOM) services and MCC in 41 clinics. The MCC contract was approved in November 2012 to integrate medical and non-medical case management into HIV care services and move toward a medical home model for HIV service delivery.
- Service guidelines are often developed after implementation, but DHSP worked to develop MCC guidelines in advance so they could form the foundation of implementation. They are evidence-based, utilize best practices and are constantly updated. Guidelines are posted on the website and attached to contracts.
- Guidelines require everyone in clinics to be screened for MCC and assessed to determine acuity level: moderate, high, severe or self-managed. Services are tracked through monthly reports. DHSP has been visiting clinics almost monthly to provide TA and do status report checks with providers. DHSP also has provided more than 10 four-day programmatic trainings for staff and holds quarterly face-to-face or conference call meetings with providers.
- The one-page screening MCC tool assesses both medical and psychosocial issues. Patients who are not identified as moderate, high or severe acuity are identified as self-managed. A significant percentage of patients are self-managed. Those patients remain enrolled in MCC and can access services through their case worker, but the three higher acuity groups are the primary focus of MCC teams. All patients are screened for MCC every six months.
- Physicians can over-ride the assessment. Consumers can request a new assessment when they present with a new condition. An emergent need can also trigger a review. Consumers may reject MCC initially, but request it later.
- The four key MCC outcome measures are: retention in care; Viral Load (VL) suppression on ART; provision of interventions, i.e., adherence and risk reduction counseling; and linkages to support services, e.g., mental health.
- Ms. Garland, Epidemiologist, Office of the Medical Director has worked closely with Mr. Vega-Matos and Care Services to oversee MCC evaluation. This data is preliminary. More complete data will be available by August.
- The purpose of the evaluation plan is to: describe and monitor fidelity to the MCC protocol; evaluate impact of MCC on health outcomes among high-risk patients at 6 and 12 months; and determine MCC service delivery costs.
- The design uses a longitudinal observational cohort to compare changes in process and outcome measures from baseline to 6 and 12 months. DHSP relies heavily on Casewatch data already routinely collected by providers. Current data includes all sites, but clinics implemented MCC at varying times so some have more data than others.
- From 3/1/2013 through 3/31/2014, MCC screening data was entered into Casewatch for 7,686 patients. Of those, 2,686 (35%) were identified as needing active MCC services. An initial MCC assessment was completed for 1,372 patients of which: 257 (19%) were self-managed; 704 (51%), moderate; 406 (30%), high; 5 (<1%), severe.
- Acuity levels are used to determine the intensity of service delivery for those receiving active MCC with hours of service increasing with acuity, e.g., severe acuity patients are assessed monthly; high, every three months; moderate every six months; and those self-managed at the initial assessment do not have another. Likewise, the time spent on care planning, monitoring and patient case conferences increases with acuity.
- Current data on VL suppression in MCC at six months is limited to Ryan White or HWLA patients because changes due to ACA reduced reliability of outpatient visit data from other payer sources. Analysis will be redone in future

after matching Casewatch with surveillance data so that surveillance data can be used as an approximation for outpatient visit data in looking at VL and retention in care data for the entire MCC population.

- Only 32% of patients had VL suppression of <200 copies in the six months prior to MCC participation. Those with VL suppression after six months of participation rose to 58%. Preliminary data appears to confirm patients needing services are being identified; services are being delivered per protocol; and services improve VL suppression.
- Mr. Vega-Matos shared key issues that have arisen during implementation. There is an inherent tension between MCC and some traditional roles of other clinic staff. Many AOM providers had no medical or non-medical case management before and often had a small nursing staff. Some now want to divert MCC team nurses to duties other than MCC. DHSP's monthly provider visits offer an opportunity to trouble-shoot such issues.
- On the other hand, providers report MCC is a catalyst to improve clinic practices that facilitate access and retention, e.g., patients can see a nurse or social worker if a physician is not available. The MCC team also enables providers to review medical records, identify patients who have been out of care for more than six months and re-engage them in care. DHSP hopes to capture activities like these in the qualitative part of the evaluation process.
- MCC teams are also often serving as anchors to linkage to care. Previously, patients entering a clinic waited for a financial eligibility screening or a quick assessment, but clinics were challenged to capture and complete linkages. The MCC team offers a venue to assess and screen patients. DHSP is looking more closely at this anchor function.
- There have been challenges with implementation because MCC is a major system change. Not all clinics were able to hire and ramp up at the same time. All clinics are now staffed though some have experienced staff turnover. Some clinics also have a challenge with the new concept of the self-managed acuity level. Self-managed patients are in MCC and generally manage their own needs, but may access a case worker as needed.
- DHSP will continue to strengthen implementation and adherence to MCC protocols. It is also committed to streamlining and improving data collection. It is drafting the preliminary Evaluation Report and will present at the Coping with Hope Conference at UCLA in May 2014. It will also be presenting at the HIV Treatment and Prevention Adherence Conference in June 2014 as well as presenting updated data to the Commission by August 2014.
- Mr. Kelly noted 19% of patient's at initial assessment were classified as self-managed. That reminded him of the Gardner Treatment Cascade that reflected 20%-25% of patients nationally had suppressed VLs. The County generally reports a higher percentage. He asked if this data will improve data on patients with suppressed VLs.
- Ms. Garland replied patients who complete the assessment were identified during screening as at higher risk for poor health outcomes, e.g., diagnosed within last six months; out of care; with detectable VLs; possibly meeting clinical guidelines for ART, but not on it; recently incarcerated. They are higher risk than County PLWH overall.
- Self-managed MCC patients may or may not have suppressed VLs. They may receive more intensive MCC services because they meet other criteria or have competing psychosocial services. She felt, however, the comparison with Treatment Cascade data was interesting and warranted further consideration.
- Mr. Smith asked about data on populations of color in MCC. Ms. Garland responded the more comprehensive evaluation will include data on such areas as: who is being served, whether MCC is more effective for some populations; and what populations decline MCC. Mr. Vega-Matos added DHSP is still collecting data.
- Mr. Ballesteros said it would be helpful if data on patients who have not achieved VL suppression could be related to potential causes, e.g., compliance or housing, Ms. Garland said assessment includes 13 domains, e.g., health status, housing, transportation, mental health, substance use, adherence and HIV care history. Acuity can be reviewed for each domain and compared by population, e.g., the virally suppressed, gender or race/ethnicity.
- Identifying MCC effectiveness for various populations will be a goal going forward to address improvements.

C. Research/Surveillance: There was no report.

14. STANDING COMMITTEE REPORTS:

A. Operations Committee:

1) Pol. #08.2107: Consent Calendar:
MOTION 5: Approve Policy/Procedure #08.2107 ***(Consent Calendar)***, as reviewed and finalized after public comment period ***(Passed as Part of the Consent Calendar)***.

2) Pol. #08.3105: Federal Conflict of Interest:
MOTION 6: Approve Policy/Procedure #08.3105 ***(Adherence to Federal Conflict of Interest Rules and Requirements)***, as revised and finalized after public comment period ***(Passed as Part of the Consent Calendar)***.

3) Pol. #08.3108: State Conflict of Interest:

MOTION 7: Approve Policy/Procedure #08.3108 ***(Adherence to State Conflict of Interest Rules and Requirements)***, as revised and finalized after public comment period ***(Passed as Part of the Consent Calendar)***.

4) **Pol. #09.7201: Consumer Compensation:** Mr. Vincent-Jones noted the stipend claim form was done. A copy was in the packet and would be reviewed at the Consumer Caucus. Detailed instructions will also be emailed by 5/9/2014**. T**he form is as simple as possible in light of Executive Office requirements to approve claims.
MOTION 8: Approve Policy/Procedure #09.7201 ***(Compensation for Unaffiliated Consumer Members' Service on the Commission)***, as revised and finalized after public comment period ***(Passed as Part of the Consent Calendar)***.

5) **Member Renewal/Nomination Plan 2014:**
   - Joseph Green, Co-Chair, reported the open nominations process for terms ending 6/30/2014 will begin 5/12/2014 and close at the 6/12/2014 Commission meeting. There is a new application for those who applied before and were not seated or for new applicants and a renewal application for sitting Commission members who would like to re-apply. The process is competitive so interviews may be required if there is competition for a seat.
   - Renewing Commission members whose seats are not competitive may request an interview at their discretion.
   - Interview panels will be similar to those employed to initiate the Commission with four or five members. Questions will also be similar with some slight adjustments to questions for renewing members.
   - The process is transparent and open to all who wish to apply including Alternates seeking a full seat.
   - Ms. Scholar said it appeared seats held by 12 of 15 women and all transgendered Commission members were terming out. She urged ensuring representativeness. Mr. Vincent-Jones said assignment of one- and two-year terms was entirely random. The Commission always pays attention to demographics and has very strict Ryan White demographic, ethnic and racial requirements among the membership as a whole and consumers.
   - Diversity and a good balance are key concerns. The application is used with an interview to score applicants. Scores are used to determine seat selection, but exceptions are made in certain circumstances such as to ensure diversity.
   - Mr. Kelly felt the subject was more a Committee report than a matter to be voted. He was also uncomfortable voting because it seemed to be presented as a policy, but was not included in the packet.
   - Mr. Vincent-Jones responded Operations brought a plan to the last Commission meeting, but it was returned for revision. The Membership Work Group met just last week. There was insufficient time to provide materials, but there are no major changes. The Commission can vote on policies, processes or conceptual plans such as this, but it is not necessary. The Commission could simply advise Operations to proceed. Terms end 6/30/2014.
   - Mr. Land thanked Operations for revising the process. He felt it was clear as described and called for a vote.

   MOTION 9: Approve proposed strategy to renew member nominations for those current members who wish to continue serving on the Commission and whose initial terms expire in June 2014 ***(Passed: 27 Ayes; 0 Opposed; 4 Abstentions)***.

B. Planning, Priorities and Allocations (PP&A) Committee: PP&A completed its work plan and will present it in June.

C. Standards and Best Practices (SBP) Committee:

1) **Population-Specific Guidelines Format:** The Format will be presented at the June meeting.
MOTION 10: Approve the proposed framework/format, as presented, for use in the development and/or revision of population-specific guidelines and to replace the format for Special Population Guidelines and Population-Based Recommendations/Guidelines ***(Postponed)***.

2) **Social Determinants Framework:** This item was postponed.

D. Public Policy Committee:

1) **Pre-Exposure Prophylaxis (PrEP) Forum:** Mr. Smith introduced Ms. Mutepfa, Senior Community Health Program Representative, David Geffen School of Medicine, UCLA who will moderate the panel. UCLA engages in HIV biomedical research. Ms. Mutepfa is an advocate for biomedical interventions and part of the Los Angeles PrEP Work Group.

   a) **PrEP Overview: What It is and What It's Not:**
      - Ms. Mutepfa emphasized she and the panel are prevention advocates who support access and utilization of every option to prevent HIV infection. She has been committed to the fight against HIV since 1993.
      - The panel's purpose is not to debate about safety, effectiveness or efficacy of PrEP since research addresses those subjects. Nor will the panel act as police, lawyers or judges to interrogate, accuse or judge. The purpose of the panel is to facilitate dialogue, remove provider bias, and share information, education and resources on using existing HIV prevention tools to stop new HIV infections in anyone who needs and requests access.

- PrEP is an antiretroviral (ARV) drug taken by an HIV- person before potential HIV exposure to reduce the risk of infection. It is a new HIV prevention approach, but the concept and practice of prophylaxis is not new.
- PrEP should be used with other safer sex practices, e.g., male and female condoms. Those using PrEP in a clinical trial, demonstration project or in collaboration with a physician should also receive regular HIV testing.
- PrEP does not prevent pregnancy, protect against STIs, is not a cure for HIV and does not work as a treatment for someone already living with HIV. PrEP does not work unless it is taken consistently and correctly.
- She thanked the Commission for the opportunity to participate in this. Working with the community the last three years was a pleasure. She is leaving UCLA 5/16/2014 and will continue HIV work outside California.

b) Why PrEP? Need, Use and Effectiveness:

- Dr. Mills is a Los Angeles based physician and leading clinician in men's health and HIV disease. He is primary care provider for over 2,000 patients including 1,000 PLWH. He advocates for PLWH, is a nationally recognized speaker on a variety of topics pertaining to HIV treatment and has extensive research experience.
- Dr. Mills has worked in the HIV field since 1985. It is frustrating that despite all the prevention efforts over the years there are still 50,000 to 60,000 new infections nationally each year. New prevention approaches are needed. PrEP has been proven to be protective. While PrEP is not right for everyone, it can be a great tool.
- A question arose concerning provider bias during a recent PrEP webinar with over 140 clinicians countrywide. Dr. Mills was struck by the politizing of PrEP. It appears there is a barrier to access especially for communities that need PrEP most, e.g., young people, Latinos and African-Americans. Providers are reluctant to discuss PrEP with their patients and it is difficult to actually have PrEP initiated.

c) Why PrEP? A Consumer Experience:

- Ernesto, the panel's community advocate, offered his experiences as a 35-year-old, mixed heritage, gay man. He recently completed a PrEP clinical trial and continues to use PrEP. He is in relationship with multiple partners and prefers dates to hook-ups. He is an executive assistant at Neiman Marcus.

d) PrEP Outcomes: Heavily Impacted Communities:

- Dr. Davis is Associate Professor, Internal Medicine, Charles Drew University and has decades of experience as a community advocate, educator, clinician and researcher. She has numerous degrees including a masters in clinical research and doctoral degrees in chiropractic medicine and preventative medicine.
- Epidemiology shows HIV infection growing most rapidly among Black women and young Black MSM so it is very harmful if communities of color are not educated about PrEP use. Many providers of color opposed PrEP initially. They felt it undermined taking responsibility for unprotected sex. Dr. Davis responds to them that women who used birth control pills were also stigmatized initially. PrEP is simply another tool in the tool box.
- Dr. Davis is the research clinician for the PrEP program at OASIS. Staff ensures participants understand PrEP is not the only key. It should be used with safer sex practices and ensuring proper cognition to negotiate sex by decreasing substance abuse. If the community is educated to see PrEP as one of many tools then the community and providers of color will understand support for PrEP does not support unsafe sex.

e) PrEP Policy: Access, Payors, Regulation:

- Mr. Fox is Co-Chair, Public Policy Committee; Director, State Health Equity and Policy, Los Angeles Gay and Lesbian Center; Co-Chair, California HIV Alliance; Member, Advisory Committee, Office of Health Equity, California Department of Public Health; Member, California LGBT Health and Human Services Network.
- Mr. Fox felt the cost of PrEP and its impact on HIV treatment was more prominent during early PrEP research. At the time, there were long ADAP waiting lists throughout the country. Most ADAP wait lists have since been eliminated and many patients have migrated from ADAP to other payer sources.
- There are two cost aspects: the cost to patients depending on their coverage and the cost to the overall system. He was most concerned with out-of-pocket costs to patients though Gilead offers some assistance. He felt usage was so low that payer source cost concerns were unreasonable.

f) Question-and-Answer – Discussion:

- A West Hollywood resident said he was 27, HIV- and not currently on PrEP. He has been in long-term serodiscordant relationships and knows their strengths. Considering the number of annual new infections and those unaware they are HIV infected, it is critical to add tools to the tool box which now primarily consists of awareness, knowledge and physical barriers such as condoms. PrEP is 99% effective if used properly.
- It is also the first tool in HIV prevention that allows the receptive partner to be 100% in charge of their health.
- Opponents call PrEP a party drug, but that stigmatizes knowledgeable people who want to stem transmission.
- PrEP is covered by approximately six national health plans and Medi-Cal. Most AIDS foundations support it.

- Approximately 1,800 people in the country now use PrEP, but that can be increased with education..
- Gabriel Green is 37, HIV- and Black mixed with Cherokee, Filipino and Irish. Most new infections are in the Black and Latino communities, but the issue in any community is lack of or inaccurate prevention education. People should be urged to know and be informed about all forms of HIV prevention to enable them to choose.
- Ms. Flanigan, 33, is not taking PrEP, but noted PrEP affects families, too. It is an issue of personal choice.
- Ernesto said he was motivated to begin PrEP because of a relationship that developed with an HIV+ man. He was concerned and then realized for 34 years he had associated sex with death. The relationship ended, but PrEP allowed him to explore the relationship without worrying about the disease.
- He did not find the protocol difficult. He takes his pill first thing in the morning and rarely forgets. He felt it easier to address his health as part of a routine rather than in the heat of the moment.
- Dr. Kushner reported the Long Beach Health Department was a PrEP site along with Harbor-UCLA, USC and UC-San Diego. Long Beach currently enrolls approximately 40 patients.
- Long Beach is also learning more about PrEP participant behaviors and STIs. That knowledge helps Long Beach assist participants with behavioral changes that can limit other STIs. It also helps Long Beach better integrate its HIV and STD services. There was initial debate about being a PrEP site, but staff now finds it is very helpful.
- Mr. Rivera reported he has heard PrEP use stigmatized at community forums by long-term survivors who feel young men today are being irresponsible. He became HIV+ during an 18-month period when crystal meth took control of his life. He felt there was a good chance he would not have become HIV+ if PrEP had been available.
- Mr. Liso related someone in his family was on PrEP during a difficult time in his life. It worked for him.
- Mr. Liso, HIV+ for 27 years, also saw PrEP as supporting healthy relationships and reducing HIV stigma. He did, however, want to ensure current guidelines and standards of care are maintained with a physician prescription. There was a proposal at the Federal Drug Administration that would loosen regulations.
- Mr. Leue clarified that regulations require pre-PrEP HIV testing to ensure the person is HIV- since Truvada may be too weak to fight an existing infection. Patients prescribed PrEP are tested every three months thereafter to ensure they are still HIV- and normal drug levels. Patients who take the medication daily should have a 90% blood level which will provide 99% efficacy. Education allows patients to make an informed choice.
- Mr. Chud has been HIV+ for years. Many people have asked to buy his Truvada even at 12-step meetings. PrEP should be available for those who need it, but urged educating the HIV+ community about dangers to themselves and others from passing on their drugs. Mr. Fox felt that phenomenon was due to lack of access.
- Mr. Ballesteros agreed data show PEP and PrEP work. We should routinely use data to implement programs that work so the question becomes not whether to use it, but how to cover those who cannot now access it.
- Mr. Fox said Gilead's assistance program covers those who lack insurance and have incomes up to 200% of the Federal Poverty Level for an individual. He felt advocacy is needed to expand options, e.g., the CDC funds administration of PrEP, but not the drug, while Ryan White and the state do not fund it at all.
- Ms. Lawson is HIV+ and a cancer survivor. She asked about pre-PrEP patient education on the prevalence of cancer for those on Truvada over time. Dr. Davis said patients are fully informed about possible side effects so they can make an informed decision. Medical monitoring is also important. Patients are given renal and liver function tests prior to PrEP initiation and every three months thereafter along with a rapid HIV test and VL.
- Dr. Davis added OASIS is adjacent to a public health clinic which referred a 29-year-old woman to OASIS the prior week. She is married to an HIV+ man and the condom broke. OASIS placed her on PEP and talked to her about PrEP, but there are few places for women to access it. That is especially problematic for Black women due to the down-low syndrome. Ms. Mutepfa noted the UCLA Care Center study is open to women.
- Another speaker added there are bisexual couples where women with women partners may also be at risk. Women generally practice safer sex, but there is at least one documented case of HIV infection in a woman-woman couple. There may also be a lack of studies for that population. Women should have access.
- Mr. Land related that he recently spoke to a 23-year-old man who had bought Truvada on the street and felt it was effective. He seemed a little giddy, active and sure of himself, Mr. Land asked him if he used condoms or was concerned about other infections. He said no. Mr. Land tried to educate him, but felt he represented a real problem in the community. In the 1980s, safer sex was a common education subject, but that has faded.
- He had initial concerns about PrEP especially regarding STDs. He now supports PrEP, but urges combining increased PrEP access with education in the community about overall prevention.
- Dr. Mills said clinical trials reviewed patient behavior carefully especially regarding whether PrEP would increase anal intercourse. Each visit included not only dispensing medication, but safer sex counseling. Studies

consistently reflect decreased high risk behavior. Clinical trials differ from current expanded access studies, but keeping PrEP in the realm of prevention with medical supervision should support decreased risk behavior.

- Ms. Scholar asked about PrEP for IDUs especially those who are homeless. She did not know about anyone in that population who had been offered PrEP. UCLA studied interest in vaccination and it was high.
- Dr. Davis reported she has one patient who injects meth and one who smokes crack. Both are on PrEP and doing well. She believes in harm reduction. Patients should not be discriminated against for ARV, PEP or PrEP.
- Ms. Enfield heard some people leave areas with high infection rates to access care elsewhere due to stigma. She asked if stigma was within communities or from outside and how to counter it for better PrEP access.
- Gabriel Green said he came out to his mother at 18. He had to leave home and lived at college for four years. He felt he had ruined his family. Coming out is especially difficult in Black and Latino communities where being gay or lesbian means there is something wrong with you. You are less than a man or woman.
- That can also lead to being on the down low and the myth that if a man sleeps with a woman and on top then he cannot catch anything. Education is necessary to counteract that, but it is also true that shame underlies behavior. Taking PrEP is admitting who I am. Shame has to be overcome to take care of oneself.
- Ms. Tula has worked in HIV for 20+ years, but her 28-year-old son recently tested HIV+. He and a young woman are in a serodiscordant relationship and want more children. He is responsible, but they cannot have children under the circumstances. PrEP should be part of the prevention tool box for anyone who wants it.
- Mr. Johnson supports PrEP access along CDC guidelines, but also urged having the fuller discussion. It felt to him, as critical as this tool is, it is also the most unstable since so much of what we are talking about and what has been sensationalized in the media is about behavior. He did not know if he would have used and adhered to PrEP when he was shooting meth and seeking sex. He was a health care lawyer who refused health care.
- We have to have the uncomfortable conversation about how we help people make sexual choices and decisions about their lives in a healthy way. None of the comments preclude that, but we should be mindful of that as a hand-in-glove approach to PrEP. Some people will make good decisions, but others of the at-risk population will need mental and emotional support and counseling services as well.
- Mr. Sanjurjo said he takes Truvada as a PLWH and his boyfriend takes it as PrEP. For the most part, the PrEP program now is a pilot with limited participants and strict rules. It should be clear that CDC guidelines or something similar will be followed closely when access expands to a more general population. He felt the pushback that has surfaced is due to concerns about ensuring regular medical appointments and testing.
- Several noted the 99% efficacy data, but that is for those who took their medication. Many in this self-selected group who begged to join the study did not take it. PrEP was much less effective for those people and many became HIV+. We should support access, but follow-up is needed as PrEP moves into HMOs and STD clinics.
- Access is not just about personal freedom similar to the birth control pill. This is a public health issue since people may acquire HIV or even develop a strain resistant to Truvada that puts PLWH at risk.
- Ms. Mutepfa noted Truvada is not branded as PrEP. Other drugs are in the research pipeline. Mr. Leue added quarterly PrEP and biannual HIV treatment injections are also under study so the adherence discussion may change soon. He urged providing information on what is here now, what is coming and the potential of PrEP.
- He reported one mutation was discovered in a study, but it did not survive because Truvada is a combination drug. There are already nine subcategories of HIV 1 as well as HIV 2 which is primarily in western Africa.
- Education is key. Sexuality is natural, but PrEP cannot be used as a party drug. Three consecutive days of doses are needed to build effective resistance. A few weeks ago he counseled a 24-year-old who was shunned and shamed at a provider for asking about PrEP. He was given a condom and sent on his way. His friend gave him pills and said to take one before and one after. He is now HIV+. People must be educated and offered a choice.
- Dr. Spencer strongly supports PrEP as a provider of color caring mostly for patients of color. The MCC Clinic primarily cares for women, children and their families dealing with HIV infection. They have done PrEP for years in the prevention of mother to child transmission.
- Due to this conversation, MCC is now using PrEP for serodiscordant couples trying to have babies. MCC offers extensive preconception counseling. PrEP is most often offered to the woman as the man is most often HIV+. Women are more likely to seroconvert during pregnancy. Babies are more likely to do so if the mother does.
- Mr. Zaldivar thanked the panel and attendees. He noted Mr. Leue is Mr. Leather 2014 and brought many from the leather community. It reminds him of AIDS activism years ago that called attention to the AIDS crisis. He supports PrEP as a gay Latino representing an AIDS Latino organization.

- We continue to demonize sex. Sexual activity will always be a concern, but we should not second guess that our people want to be educated about PrEP and will use it appropriately. Alcohol contributes more to HIV and is common at pride parades and festivals with no discussions about decreasing use. There should be more education about all the tools especially in the Latino community.
- Ms. Forrest works primarily with homeless substance abusing people who do not know their status. There is a great deal of shame and stigma especially for those using crystal meth. It may be from family or other social institutions, but also from our community. We should be able to bond with those in our own community.
- Mr. Fox said opposing opinions are usually about how people choose to behave in their sexual lives. Those opinions have always been there. The first page of the CDC sheet states PrEP is safe and effective in preventing HIV. That is science. We need to ostracize opinions, as we are doing here, and support science so that people can choose to empower and protect themselves without shame or judgment.
- Mr. Senterfitt is a prevention research scientist, public health worker, activist and has lived with HIV for more than 25 years. PrEP, if used according to guidelines, is a safe and effective means of HIV prevention. PrEP and knowledge about it should be available to everybody in the community.
- Regarding adherence and other STDs, there is an opportunity to address all the other needs such as health overall, mental health and substance abuse once someone is brought into care. Evidence to date has shown PrEP does not increase risk behavior. There are questions about how data will translate to routine PrEP, but some of the organizations most opposed to PrEP have opposed efforts to do practical demonstration projects.
- Data shows people in care for HIV reduce their transmission risk behavior by 60% to 80% just by being in care.
- He was a veteran of Act Up and President of Being Alive for many years. If someone said in the late 1980s and early 1990s that a pill you could take every day would prevent HIV, they would have clamored all over town to ensure it was available. They would have demonstrated at the County to ensure it was funded and at any so-called community organization trying to stop access by badmouthing it. They would have said, “Look, we may have different opinions, but this is something that has been proven to work. Let us have it. Let us figure out how to make it available to everyone in our community.” What are we waiting for?
- Dr. Cadden believed in education, but there has been safer sex education for 30 years. It has gone as far as it can. PrEP is the next best option and has great potential. The debate is not whether to use it, but how to do it best with the fewest mistakes. We know how the medication works. Make sure providers are educated on how to best roll PrEP out and understand the need to adhere to CDC guidelines to achieve the same result.
- Mr. Lopez asked about PrEP access for the Latino community especially the undocumented. Mr. Fox replied current law prohibits Ryan White from funding services for HIV- people, but that could change. There are also efforts in California to cover health care for all Californians. Ms. Mutepfa added there are five clinical trials at eight sites as well as demonstration projects that allow anyone to enroll in PrEP
- She continued that advocacy within the Latino community is important. AltaMed is planning some activities and the Los Angeles County PrEP Work Group will hold a provider forum for the Latino community at the California Endowment on 8/29/2014 that will specifically address ways to increase access.
- Mr. Pérez affirmed that DPH and DHSP fully endorse biomedical interventions as part of our HIV prevention tool box. There is no question it needs to be a critical part of the prevention strategy.
- A couple of things are currently in place and others need to be explored with public and private partners.
- Two nPEP sites are in place at OASIS and GLC, but more are needed. He appreciated the PrEP discussion, but work also remains to ensure nPEP access is commensurate with demand. Exploring site expansion to other areas, particularly epicenters such as Long Beach and the San Fernando Valley, is a key planning question.
- We are lucky in Southern California to likely have the highest number of PrEP demonstration sites in the country, but public and private health plans and patient assistance programs are also critical opportunities for patients to have access to PrEP. Demonstration projects are important in providing real world experience on, e.g., access issues and a comprehensive menu of sexual health services. That must be part of the conversation.
- Just providing a pill a day does not address the high and increasing rates of STDs. Patients need to be screened to ensure they are HIV- so they do not take PrEP unnecessarily and patients also need ongoing follow-up.
- Patients will begin to roll off of demonstration projects in May. DHSP is working to develop options for them as a public health entity and HIV prevention partner, but there are other stakeholders, e.g., public and private health plans and others providing services and care. All need to work together to ensure access. DHSP remains the safety net, as it is in other areas, to ensure people have the tools they need to remain HIV-.

- Planning conversations on standards of care, funding and collaboration with stakeholders should start now. They will need to address the uncomfortable subject of what services need to be funded at a lower level to increase nPEP and PrEP funding. That does present a good opportunity to asses the County's prevention response along with its strengths and opportunities for improvement tied to it.
- There has been a slight decline in new infections, but the County still reports a little more than 1,900 annually or nearly 10,000 new PLWH in the County in five years for a total of 70,000. We must avert that.
- Mr. Fox noted Motion 11 and associated material was distributed prior to the meeting for advance review.
- Mr. Kelly asked if there was a Motion 11 implementation plan, i.e., what various committees would do. Mr. Fox responded Public Policy felt the first step should be a Commission policy statement in light of the amount of inaccurate information and confusion in the community. Implementation will be reserved for a later plan.

MOTION 11: Support the approval, use, dissemination, payment and sustainability of biomedical interventions – particularly microbicides, Post-Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP) – as HIV prevention strategies, and promote access, availability and awareness of them to HIV-negative and –positive consumers, providers and health plans, in accordance with recommendations and guidelines by the CDC and other federal oversight agencies, as appropriate. In particular, prioritize the following Commission efforts in pursuing these goals and objectives:

- Affirm the use of and improve access and availability to PrEP, PEP and related biomedical interventions in accordance with the appropriate CDC guidelines to the healthcare community, local providers, and local and state health plans and agencies;
- Promote the awareness and availability of and access to PrEP, PEP and related biomedical interventions to HIV-negative and –positive consumers; HIV, healthcare and human service providers; and public and private health plans through referral and information activities, community awareness, and education and training opportunities;
- Define allowable service models that will enable the best and most effective delivery and distribution of PrEP, PEP and related biomedical interventions that adhere to the recommendations and guidelines of the CDC and other federal and state healthcare and oversight agencies;
- Assess and advance methods to ensure ~~PrEP~~ *all biomedical interventions and nPEP* programmatic and fiscal sustainability in local service continua, statewide and nationally;
- Advocate for expanded authorization to fund the full use and delivery of PrEP, PEP and all other approved biomedical interventions in the Ryan White Program, CDC-funded HIV prevention activities, and in other, relevant federal, state and local HIV care and prevention services and healthcare settings;
- Strongly urge and facilitate the introduction, distribution, and prescription of PrEP, PEP and other biomedical interventions into Los Angeles County's own health and public health programs and services and among both local funded and non-contracted HIV and healthcare providers and agencies ***(Passed by Consensus)***.

2) 2014 Policy Agenda:

- Mr. Fox noted there was some confusion at the last meeting. The numbers under policy priorities do not reflect priorities as is noted in the preceding sentence where it confirms priorities are in "no particular order."
- Commission comments have been incorporated into the agenda.

MOTION 12: Approve the proposed 2014 Policy agenda, in accordance with suggested amendments and further review, as recommended at the 2/13/2014 and 3/13/2014 Commission meetings, and rescind the vote opposing such approval at the 4/10/2014 Commission meeting ***(Passed by Consensus)***.

3) 2014 Legislative Docket:

- Mr. Fos reported the Committee reviewed Commission comments. Revisions are reflected on the docket.
- The AB 1576, adult films, position was changed from support to watch with a recommendation to the author to include language that requires employers provide no cost PrEP and PEP to their employees.
- AB 1805 was added to the docket. It allows registrars and recorders to waive fees for certificates of live births and other forms of identification for those who self-attest to being homeless. The Committee supports the bill because it would make it easier for the homeless to obtain documents needed to apply for and receive services.
- Mr. Land asked about HR 3717 and MICRA. The Committee considered both and chose to take no action.
- Mr. McMillin asked about position revision pertaining to SB 1150. Mr. Fox responded there were no changes. The Committee acknowledged some misunderstanding about the bill which increases the allowable number of FQHC patient visits reimbursable per day from one to two. The Committee recommends lifting the cap altogether.
- Currently, FQHCs cannot bill, e.g., for a primary and mental health visit on the same day so patients often have to make multiple visits to meet their needs. The Committee would prefer no cap, but felt this bill improves access.

MOTION 12A: ***(Fox/Cadden)***: Return Motion 13 to the table ***(Passed by Consensus)***.
MOTION 13: Approve the 2104 Legislative Docket detailing Commission positions on pending legislation and forward those recommendations to Intergovernmental Relations (IGR) in the County's Chief Executive Office (CEO), the Board of Supervisors, and other departments, as appropriate ***(Passed by Consensus: 1 Abstention)***.

4) **City of LA AIDS Coordinator's Office Budget:**
   - Mr. Zaldivar credited City Councilmen Gil Cedillo, who re-allocated funds from Lincoln Park to help bridge the three-month funding gap, and Herb Wesson among others providing support from the City. He felt the Commission's letter to the City was valuable in affirming the body's support for the AIDS Coordinator's Office.
   - Mr. Fox recognized Ms. Scholar for community mobilization at the budget meeting. Ms. Scholar added every Budget and Finance member stood to support HIV services. Two spoke about people they knew in recovery.
   - Mr. Rosales reported half of the funds have been allocated through the City CDPG program, He provided testimony at the 5/2/2014 Budget and Finance Committee meeting regarding the other half. That funding will be via a separate process and funding pool from the regular City budget. Work continues.
   - ➲ Mr. Rosales will continue to update the Commission on progress.

15. HOPWA REPORT: This item was postponed.

16. CAUCUS REPORTS: This item was postponed.

17. **TASK FORCE REPORTS**: This item was postponed.

18. CITY/HEALTH DISTRICT REPORTS: This item was postponed.

19. AIDS EDUCATION/TRAINING CENTERS (AETC): This item was postponed.

20. **SPA/DISTRICT REPORTS**: This item was postponed.

21. **COMMISSION COMMENT:** There were no comments.

22. ANNOUNCEMENTS: There were no announcements.

23. ADJOURNMENT: The meeting adjourned in memory of Henry Van Oudheusden and Jean Werner at 2:20 pm.

A. Roll Call (**Present)**: Ballesteros, Cadden, Donnelly, Ferlito, Fox, Garbutt, Goddard, Granados, Green, Holloway, Johnson, Kelly, Kochems, Kushner, Land, Lawson, Lester, Liso, Lopez, Martinez, McMillin, Munoz, Palmeros, Pérez, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca, Scholar, Smith, Spencer, Tula, Zaldivar

MOTION AND VOTING SUMMARY		
MOTION 1: Adjust, as necessary, and approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve minutes from the February 13, 2014, March 13, 2014 and April 10, 2014 Commission on HIV meetings, revised as appropriate, as presented.	***Postponed***	**MOTION POSTPONED**
MOTION 3: Approve the Consent Calendar with agenda motions 4, 9, 10, 11 and 12 removed.	***Passed by Consensus***	**MOTION PASSED**
MOTION 4: Modify FY 2013-2014 Ryan White Part B [State Office of AIDS (OA) Single Allocation Model (SAM)] allocations to include approximately $1,000,000 for residential care, in order to fully maximize Part B funding by the end of the State OA funding term.	***Ayes:*** Ballesteros, Cadden, Donnelly, Enfield, Espinoza, Fox, Garbutt, Granados, Green, Johnson, Holloway, Kelly, Kochems, Kushner, Land, Lawson, Lester, Liso, Lopez, Martinez, McMillin, Munoz, Palmeros, Pérez, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca,	**MOTION PASSED** **Ayes**: 34 **Opposed**: 0 **Abstentions**: 2

MOTION AND VOTING SUMMARY		
	Scholar, Smith, Spencer, Tula, Zaldivar ***Opposed**:* None ***Abstentions**:* Goddard, Kiburi	
MOTION 5: Approve Policy/Procedure #08.2107 ***(Consent Calendar)***, as reviewed and finalized after public comment period.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 6: Approve Policy/Procedure #08.3105 ***(Adherence to Federal Conflict of Interest Rules and Requirements)***, as revised and finalized after public comment period.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 7: Approve Policy/Procedure #08.3108 ***(Adherence to State Conflict of Interest Rules and Requirements)***, as revised and finalized after public comment period.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 8: Approve Policy/Procedure #09.7201 ***(Compensation for Unaffiliated Consumer Members' Service on the Commission)***, as revised and finalized after public comment period.	***Passed as Part of the Consent Calendar***	**MOTION PASSED**
MOTION 9: Approve proposed strategy to renew member nominations for those current members who wish to continue serving on the Commission and whose initial terms expire in June 2014.	***Ayes**:* Ballesteros, Cadden, Donnelly, Fox, Garbutt, Goddard, Granados, Green, Johnson, Holloway, Kushner, Land, Lawson, Lester, Liso, Lopez, Munoz, Palmeros, Rios, Rivera, Rosales, Rotenberg, Scholar, Smith, Spencer, Tula, Zaldivar ***Opposed**:* None ***Abstentions**:* Kelly, Kochems, McMillin, Pérez	**MOTION PASSED** **Ayes**: 27 **Opposed**: 0 **Abstentions**: 4
MOTION 10: Approve the proposed framework/format, as presented, for use in the development and/or revision of population-specific guidelines and to replace the format for Special Population Guidelines and Population-Based Recommendations/Guidelines.	***Postponed***	**MOTION POSTPONED**
MOTION 11: Support the approval, use, dissemination, payment and sustainability of biomedical interventions – particularly microbicides, Post-Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP) – as HIV prevention strategies, and promote access, availability and awareness of them to HIV-negative and –positive consumers, providers and health plans, in accordance with recommendations and guidelines by the CDC and other federal oversight agencies, as appropriate. In particular, prioritize the following Commission efforts in pursuing these goals and objectives: ▪ Affirm the use of and improve access and availability to PrEP, PEP and related biomedical interventions in accordance with the appropriate CDC guidelines to the healthcare community, local providers, and local and state health plans and agencies;	***Passed by Consensus***	**MOTION PASSED**

MOTION AND VOTING SUMMARY		
▪ Promote the awareness and availability of and access to PrEP, PEP and related biomedical interventions to HIV-negative and –positive consumers; HIV, healthcare and human service providers; and public and private health plans through referral and information activities, community awareness, and education and training opportunities; ▪ Define allowable service models that will enable the best and most effective delivery and distribution of PrEP, PEP and related biomedical interventions that adhere to the recommendations and guidelines of the CDC and other federal and state healthcare and oversight agencies; ▪ Assess and advance methods to ensure ~~PrEP~~ *all biomedical interventions and nPEP* programmatic and fiscal sustainability in local service continua, statewide and nationally; ▪ Advocate for expanded authorization to fund the full use and delivery of PrEP, PEP and all other approved biomedical interventions in the Ryan White Program, CDC-funded HIV prevention activities, and in other, relevant federal, state and local HIV care and prevention services and healthcare settings; ▪ Strongly urge and facilitate the introduction, distribution, and prescription of PrEP, PEP and other biomedical interventions into Los Angeles County's own health and public health programs and services and among both local funded and non-contracted HIV and healthcare providers and agencies.		
MOTION 12: Approve the proposed 2014 Policy agenda, in accordance with suggested amendments and further review, as recommended at the 2/13/2014 and 3/13/2014 Commission meetings, and rescind the vote opposing such approval at the 4/10/2014 Commission meeting.	***Passed by Consensus***	**MOTION PASSED**
MOTION 13: Approve the 2104 Legislative Docket detailing Commission positions on pending legislation and forward those recommendations to Intergovernmental Relations (IGR) in the County's Chief Executive Office (CEO), the Board of Supervisors, and other departments, as appropriate.	***Passed by Consensus*** ***Abstentions:*** Pérez	**MOTION PASSED** **Abstentions**: 1